example, one talk on skin disease is accompanied by a series of 24 transparencies and two diagrams.

Members on our list receive tapes or disks at regular intervals, but they can, on request, have a particular recording again, perhaps for a meeting, as can any other member of the College.

Also available on request to members are a number of recordings which will form the nucleus of our library. These include recordings of notable College occasions such as the James Mackenzie Lecture, and more detailed talks on subjects, such as more advanced psychiatry, which have been asked for by members but may not appeal to all.

The Discussion Tape.—This is a new feature of the service, which is still experimental. Accompanying each recorded talk to listeners with tape-recorders is a blank reel of tape. After hearing the lecture, each listener has five minutes of tape to record his own comments, ask questions, and air his views. This tape will go round a second time so that the earlier speakers can hear the whole discussion—about half an hour if each member of the circuit adds something. In some cases the original lecturer will answer the questions and round off the discussion before the completed tape goes out again. This is a very popular idea, as even the shyest listener can have his say, without fear of interruption, with as much time as he likes for preparation. The following comments, taken from part of the first discussion tape, give some idea of the response.

"Two colleagues came 12 and 6 miles and felt it well worth while, and we had a stimulating discussion . . . the Medical Recording Service is doing a real service to medicine . . . unenlightened G.P.s can be shown the virtue of joining the College through the virtuosity of its members."

"This was a thoughtful and well-delivered address, and held my interest throughout. . . . The contributions of the others before me were of almost as much value as the lecture."

"My partner and I had a very enjoyable evening listening to the talk and discussing it."

"If I'd been the first . . . I think I'd have said I'd rather have read the lecture, but now I see how much better it would have been if I'd invited other doctors to listen with me. I hate psychiatry and fear mentally upset people, so to make up for it I used to read a lot, but it only made me feel more inferior. This talk has shown me that perhaps I've been approaching the subject in too highbrow a fashion. . . . You've done me a lot of good."

They all described their own problems and asked questions, comparing notes with one another. It is impossible to convey in print the excitement of hearing the voices of doctors, separated by hundreds of miles from the lecturer and from one another, discussing their reactions to a talk that they had listened to, as if together. Except for short intervals of time, they *were* together, and it should be remembered that tape, needing no processing and quickly copied, can be sent directly after a lecture or event to listeners anywhere, probably more quickly than it could be put into print.

Plans for the Future

Talks will continue to be sent out at regular intervals, and we shall hope to cover a large field of subjects. Our aim, however, will always be to direct attention to, and stimulate interest in, other methods of education, particularly discussion groups.

We are experimenting with recordings of heart sounds and other subjects, to see whether we can make use of them, as some subjects are more suitable than others, and an enormous amount of research on technical points needs to be done. We hope eventually to build up a comprehensive library for the College, so that any member will be able to obtain an up-to-date talk or course in any subject. Recordings of historical interest to the College will be collected for its archives.

We hope overseas members will be able not only to listen to our recordings, but to send us some of their own, so that real contact can be made with them.

In these ways we hope to advance a step further the work that the College has already done in bringing together its members and giving them a feeling of brotherhood and unity of purpose.

We thank Smith Kline and French Laboratories Ltd. for paying for the production costs of both the original trial and the present Medical Recording Service; and John Hassell Recordings for technical advice and help. Also the countless members of the College of General Practitioners whose enthusiasm and help made the idea become fact.

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PSYCHOLOGICAL MEDICINE IN GENERAL PRACTICE

A REPORT PREPARED BY A WORKING PARTY* OF THE COUNCIL OF THE COLLEGE OF GENERAL PRACTITIONERS

A working party of the Council of the College of General Practitioners was appointed to study psychological medicine in general practice, after a request had been received from the Ministry of Health for the views of the College on this subject. It accepted as a definition of *psychology* "The science which deals with the mind and mental processes," and of *psychiatry* "The recognition and treatment of diseases of the mind" (*Stedman's Medical Dictionary*).

First, written evidence was obtained from 27 members of the College who had expressed a special interest in psychology and psychological medicine in a general practitioner's work. Next, details of the teaching of these subjects were sought from all medical schools in the British Isles and from some in the Commonwealth. A draft report was then sent to the Association of Teachers of Psychiatry in Undergraduate Medical Schools, to members of the Psychological Medicine Committee of the British Medical Association, the Royal Medico-Psychological Association, and the Society for Psychosomatic Research, to all members of the Council of the College in the United Kingdom and Eire, to many consultant psychiatrists, and to others.

This report, which has now been submitted to the Ministry's Standing Advisory Committee on Mental Health, discusses the importance of this branch of medicine in general practice, and the types of psychological illness seen by family doctors; it examines the leading part that should be played by all family doctors in this work, and the undergraduate and postgraduate instruction they require; it points out the help that may be given by a general practitioner with a special interest in the subject, and his particular needs at present; and it makes six recommendations.

Importance of Psychological Medicine in General Practice

Every good family doctor must be a good psychologist, for psychological medicine is part and parcel of all general practice. To misdiagnose organic disease has long been regarded as a serious error; it is now appreciated that to miss psychological illness is just as bad and may lead to even greater unhappiness. So much

*Members of the Working Party: Dr. C. A. H. Watts (Ibstock) (chairman); Dr. S. I. Abrahams (London) and Dr. J. H. Hunt (London) (joint honorary secretaries); Dr. Annis C. Gillie (London); Dr. J. P. Horder (London); Dr. Richard Scott (Edinburgh).

of medical teaching is concerned with organs and tissues that students, their teachers, and family doctors sometimes lose sight of the patient as a person whose anxieties, fears, griefs, rages, guilts, and inadequate relationships with other people can, and do, make him ill. When a person brings such a trouble to his doctor, both of them at first may be genuinely unaware that it is related to emotional upset, the significance of which may emerge only during treatment. All medical training should convince students that the person who is ill is as important as the illness from which he suffers, and that the kind of doctor is often as important as the kind of patient he is treating (Bomford, 1958). Psychological illness is one of the most pressing matters confronting the medical profession to-day; in this report only those aspects of it which are of special significance to general practitioners are considered.

The psychological problems which confront family doctors have been listed by the working party. One difficulty in compiling such a list is lack of a common classification; another is that any assessment of their incidence can only be approximately correct. The percentage of people reported with psychological illness in any general practice depends not only on the type of practice but also on the assessor, his diagnostic skill and criteria, and on his attitude towards his patients. Pemberton (1949) found 6.5% and Paulett (1956) 70% over a five-year period, while the generally accepted figure is in the region of 30%. The true incidence is probably more uniform from one practice to another than these studies suggest. The more we attempt to elucidate this subject the more impressed are we by its purely quantitative aspects.

Types of Psychological Illness Seen in General Practice

Psychological illnesses seen by family doctors fall into five main groups, which frequently overlap.

1. Anxiety and Depression from Emotional Stress

All people suffer from transient anxiety and depressive states due to the inevitable bereavements, disappointments, stresses, and strains of life. They usually get over them on their own, helped perhaps by the sympathetic understanding of a relative, friend, or minister of religion. Many symptoms are produced by such emotional upsets, from headaches, insomnia, or palpitations to anything else of which a patient may possibly complain. In children, behaviour disorders—from tantrums to truancy—often take the place of subjective symptoms; their understanding and treatment are an important part of general practice. Every organic illness has its natural psychological component, which may be mild and hardly noticed or severe; some are more likely than others to be accompanied by superadded emotional upset—for example, cancer, venereal disease, arthritis, heart attack, or stroke. Certain symptoms are particularly prone to cause reactive anxiety or depression, such as pain, bleeding, a lump, failing vision, deafness, or infertility. Influenza, sinusitis, and jaundice are sometimes associated with, or followed by, an unusual degree of depression, which also occurs after treatment with certain drugs (sulphonamides, reserpine), and after deep *x*-ray therapy. Rehabilitation following any serious injury or illness brings its own emotional problems.

2. Constitutional Liability to Anxiety or Depression

When some sensitive and imaginative people are subjected to stress they may develop anxiety or depressive symptoms which last longer than normal. This group embraces not only the weaklings but also many of the outstanding thinkers, leaders, scientists, doctors, teachers, artists, musicians, poets, lawyers, and churchmen of every generation. When stress produces incapacitating symptoms for a long time, or when these develop without adequate cause, there is often evidence of some degree of inherited nervous predisposition. Mild endogenous depression developing insidiously, with symptoms which may be referred to any part of the body, is one of the commonest psychological disorders met in general practice. It gives rise to much transient disability and unhappiness; it responds well to modern treatment; and yet not to recognize it, or to mistake it for organic disease, is possibly the most frequent diagnostic error made in medicine to-day. Some hypochondriacal and obsessional states (with phobias) also fall into this group. Other people suffer from illnesses on the borderline between physical and psychological disturbance—premenstrual tension, spastic colon, ulcerative colitis, asthma, or eczema. The aetiology of these is often partly constitutional and partly bound up with emotional state. It must never be forgotten that mind and body are interrelated and interdependent components of the whole, and that emotional conflict has profound effects on function and physical condition, and vice versa. The constitutional nature of many of these disorders must be clearly recognized. In the present state of our knowledge many of these people have to be supported and managed by their family doctors, rather than cured, so as to make life tolerable not only for the patients themselves but also for their families, neighbours, and all others associated with them.

Mild episodes of stress disorder do not require skilled psychiatric attention, any more than do the slight bruises and strains received in everyday life need the care of an orthopaedic surgeon. When symptoms are severe, however, expert psychological treatment may be wanted. Not every doctor likes this kind of work or is temperamentally suited to it; many have not had appropriate training or experience; and some deliberately avoid it, for they find such patients time-consuming, embarrassing, boring, or just "difficult." Such likes and dislikes apply also to other branches of medicine. Some family doctors, on the other hand, have a special aptitude for psychological treatment which patients soon recognize and appreciate; and much of this work is well within the scope of general practitioners who are interested and have been trained in this subject. Many experienced family physicians, in the past and to-day, have taught themselves the art of how best to handle these patients, often highly successfully. Younger doctors can now be greatly helped by proper undergraduate and postgraduate instruction.

3. Other Constitutional Personality and Behaviour Difficulties

The majority of personality upsets and behaviour difficulties met in general practice lie on the fringe of normality; but they have to be recognized and taken into full account by a general practitioner trying to assess and manage an ill person. When more severe they include antisocial behaviour and delinquency, alcoholism and other addictions, sexual perversion, and hysteria in all its manifestations. Most of these need specialist advice and treatment, but not all can be cured; many of the remainder, when they ask for help, can be usefully supported over long periods by their family doctors.

4. Organic Brain Disease

The management in their homes of patients with psychological symptoms associated with organic disorder of the brain (after head injury, in epilepsy, in mentally subnormal children, arteriosclerosis, cerebral tumours, and so on) is another important part of a general practitioner's work.

5. Psychoses

Schizophrenia, severe manic-depressive psychosis, and the psychotic later stages of many organic cerebral diseases are comparatively rare in general practice; but the unique part that a general practitioner can play in their early recognition may be of supreme importance both to the patient and to his family. Involutional depression and arteriosclerotic senile dementia are by no means uncommon, and may be a heavy burden on a busy doctor, especially in patients who prove uncooperative or suspicious. In future it is likely that a larger proportion of patients in mental hospitals may be helped enough by modern treatment to be returned to their homes under the care of their general practitioners.

Psychological Medicine in the Work of all Family Doctors

In the treatment of people with psychological illness every general practitioner starts with an advantage over the consultant because of his knowledge of his patients and the background against which they live their lives, his accessibility to their families, and the continuity of his contact, perhaps over generations. He is the person best fitted to manage the great majority of psychological ailments. His predecessor, the old-time family physician, with his commonsense approach, did extremely well in this field as confidant, counsellor, and supporter of the families under his care. To-day the general practitioner's opportunities to know his patients and to help them psychologically are still unique, especially in country practices where he is part of their environment. He lives among them, and has many close ties with them. He knows their family histories and past histories; he may be present when they are born, married, or dying; he examines them in his surgery or visits their homes when they are sick; he sees them at work and at play; and he knows how they usually behave. In course of time he may learn much about their characters and personalities, troubles and anxieties, sympathies and affections, responsibilities and ambitions, and their habits with regard to smoking, alcohol, and medicines; and he probably knows something about their morals.

A good family doctor, with this background of continuing friendly interest in the lives of his patients, can listen with understanding and consideration while they talk freely about their difficulties. By sympathetic explanation, reassurance, advice, and support, and with suitable medicinal treatment, he can, by himself, help them enormously. The first interview in any illness is often the most important. Sometimes a full physical examination is required before reassurance can be given; although, when the basis of the trouble is clearly emotional, much may be gained by indicating this to the patient at the outset. Expert listening will comfort many worried people; and repeated or extended interviews may perhaps be needed to enable some patients to work through their various problems. This simple psychotherapy and the privilege of this intimate personal doctor–patient relationship, with its mutual trust, affection, and confidence, has always been and will always be cherished by both patients and their family medical advisers. It may take up time which cannot readily be spared; but, if the emotional nature of the illness is not recognized, quite as much time, or even more, may be spent over the years trying to control a hypothetical, non-existent organic disorder.

There are certain limitations to this relationship which should be clearly appreciated. In large town and city practices, with enormous lists and nomadic populations, it is impossible to attain the ideal expressed above; but the better the doctor the nearer he approaches it. However friendly a family doctor may be with his patients, it sometimes happens that they fail to enlarge on their private worries, and keep much deeply hidden for years. The very closeness of a general practitioner to other members of a patient's family or friends, especially if they mingle in the same social set, will often be a bar to the revelation of embarrassing feelings or events which the patient may prefer to discuss with a complete stranger. For instance, a young woman may not disclose frankly a personal difficulty because her general practitioner may be thought to be too nearly identified with the points of view of her parents; she may prefer to take her problem to another. No doctor should feel hurt if a patient decides to discuss a private problem with a more distant, neutral adviser.

The family doctor has many allies in this field, and if he fails to make the best use of them he will provide less than the optimum service to his patients. They include his partners, assistants, and consultants; the patient's relatives, friends, or employer; medical officers of health; psychiatric and other social workers, State-registered nurses, health visitors, midwives, and almoners; domiciliary occupational therapists, physiotherapists, home helps, and citizens' advice bureaux; the clergy, teachers, marriage guidance counsellors, and qualified lay psychologists; duly authorized officers, probation officers, and the local representatives of a great variety of other statutory and voluntary social organizations. Every attempt should be made to link up general practice with these social and other services. Some patients will derive more benefit from them than will others. Everyone realizes that school problems can often be settled by consultation with a teacher, and the educational psychological service can be of great value in managing these difficulties in children. Sometimes it is only the minister of religion who has access to a person's confidence; religious faith can play a large part in helping many people.

The family doctor needs to have more than a nodding acquaintance with this vast army of potential colleagues. He must know something of them all, and develop special skills and techniques in establishing good relations with them, and in working with them as a team. The development of team skills has received much less formal attention in general practice than it has in hospital medicine. A general practitioner should make use of everything and everyone who can help to modify his patient's environment for the better, or at least to mitigate some of the adverse factors in it; to marshal the resources of family and State in order to aid and rehabilitate the patient, and to reintegrate him into the community to which he belongs. A change in a patient's attitude to his social environment or personal relationships is needed far more often than a variation in blood chemistry by the use of drugs; but unfortunately such a change is often impossible, and then a person may need support, perhaps over many years, from his family doctor and the social services. In the development of these team skills the general practitioner can operate most effectively if he retains control and accepts the challenge of responsibility and leadership, taking it upon himself to introduce his patients and interpret their needs to his various helpers. Sometimes it is his duty to protect those under his care from a superfluity of opinions and advice.

Responsibility for mental health in this country, in future, will rest more and more on the general practitioner. A great deal remains to be done before he is skilled enough, and adequately equipped, to do the good work in this field of which he should be capable. There are encouraging signs already of a closer liaison, better understanding, and a new pattern of co-operation between him, his psychiatric specialist colleagues, and a great variety of social agencies. The development of this team-work in the National Health Service will ensure the best use of community resources which have, so far, been inadequately tapped.

The Teaching of Psychological Medicine to all Family Doctors

Undergraduate Training

To survey the present teaching of psychology and psychological medicine, the working party asked for information from all medical schools in the British Isles and from some in the Commonwealth. The response was prompt and generous; and, in addition to the information asked for, many correspondents gave helpful opinions on the ways in which the teaching of students could be improved. The answers revealed remarkable differences. In some schools as many as 20 lectures on psychology are given during each clinical course; in one it is not taught at all. One school provides as much as 66 hours of psychiatric lectures; in another the psychiatrist has stopped giving formal lectures because he considers that clinical demonstrations are better. Compulsory attendances at psychiatric out-patient departments vary from 0 to 20, and at teaching rounds on in-patients from 0 to 24. All medical schools provide demonstrations at mental hospitals, but the number of these varies from 4 to 12. Some schools arrange for students to live in for a while in a neurosis or mental-disease unit; it has been found that advantage is taken of this and that it is appreciated. Many teachers are pressing their universities or medical schools to increase the training of students in psychological medicine, and the medical curriculum is being reviewed with this in mind.

Several criticisms from medical teachers refer to the examination system. In the final examinations of some universities there are compulsory questions in psychological medicine, and a psychiatrist is among the examiners; in others there is, as yet, no compulsory question or psychiatric examiner. This has called forth protests: "I doubt whether students will ever take psychiatry seriously until it is a compulsory part of the final examination." "It is felt by the school council that attendance at psychology lectures should not be made compulsory, as it is not yet an examination subject." "The main future requirement is a compulsory question in psychiatry." Several teachers write of their desire to integrate psychological medicine with other subjects: "It would be much better and more effective if the student got these principles from everyone rather than from the specialist in psychological medicine." One teacher sums up a widespread opinion as follows: "If a third or more of all illness has its seat in the patient's mind, however somatically it be expressed . . . psychological medicine must be taught far more widely."

A grounding in the humanities while at school is of value in acquiring maturity and wisdom. In undergraduate teaching it is clear that greater emphasis needs to be placed on psychological medicine, and an outline of normal psychology should be part of every medical student's training alongside anatomy and physiology. The General Medical Council (1957) noted: "Instruction should be given in the elements of normal psychology. . . . It is desirable that the student should be given opportunities to learn something of the work of the general practitioner. During his study of all clinical subjects the attention of the student should be continuously directed by his teachers to the importance of the interrelation of the physical, psychological, and social aspects of disease. . . . Instruction should be given in the principles of Preventive Medicine, and on the influence of heredity and environment in the widest sense on health and disease. Where appropriate the various agencies established by local authorities as part of the Public Health and Social Welfare Services should be utilized for this purpose. Instruction in Psychological Medicine should be carried out mainly in a psychiatric department, where neuroses and psychoneuroses can be studied, and should include demonstrations at a Mental Hospital, and at a Mental Deficiency Institution."

Throughout hospital training no effort should be spared to teach students the human aspects of illness, and the importance of human relationships, to persuade them to view every patient as a sensitive person with whom they must establish direct contact. They must be taught the technique of listening—an art which can be learnt. Some students show an intuitive skill in handling patients, but they, too, need to be helped by careful instruction. A knowledge of psychological medicine should pervade all clinical teaching; and consultants in all departments must recognize the importance of emotional influences. Students must be taught not only about diseases and injuries but also about the individuals who suffer from them. Even a fractured femur should never be considered in front of students without some sincere attempt to assess the degree of psychological stress which the accident has imposed on the patient and his family. A considerable change of outlook towards psychological illness is already taking place among clinicians practising and teaching in our medical schools.

Consultants and specialists in teaching hospitals must find it difficult to appreciate the problems which arise during treatment of a patient at home, and the point of view of a family doctor, unless they have themselves worked for a while in general practice. There is much to be said for part of a student's introduction to patients to be against their home background, as in the student-attachment schemes which are now being developed by many medical schools (College of General Practitioners, 1957). Before a young doctor starts in practice he should know something about the social agencies which can help his psychological work, and how he can best contact them. A large proportion of the students who qualify enter general practice, and certain lectures on the management of psychological problems by family doctors could well be given by general practitioners interested in this subject; a list of such lectures has been drawn up. There is a limit to what an undergraduate can absorb in these matters, set by the limitations of his own experience of life. A young unmarried person cannot fully appreciate the problems of marriage, parenthood, and the interpersonal relationships arising from them. Sympathy in its true sense—the ability to feel with the patient—can sometimes be achieved only as the result of considerable personal experience of emotional difficulties. After a few years in general practice, young doctors are much better able to understand their patients' psychological troubles because they themselves have had to face up to comparable problems in their own lives.

Postgraduate Training

All family doctors, young and old, should be given the opportunity to keep up to date with modern thought and teaching in this subject, and to fill gaps in their training. There are several ways of doing this. They can be encouraged to spend more time seeing their patients in consultation with more experienced general-practitioner colleagues and with psychiatric specialists, although it is appreciated that many of the latter prefer to interview patients alone. The division between hospital or institutional services for psychological illness and the services provided by general practitioners is too sharp; more consultations between family doctors and psychiatrists can be arranged as a potent means of mutual education. Doctors can read more medical journals and books on psychological medicine; there are increasing numbers of articles and monographs on this subject being published now. They can attend lectures, demonstrations, ward rounds, and refresher courses, such as those held at the Maudsley Hospital by the Institute of Psychiatry of the British Postgraduate Medical Federation of the University of London, and at the Uffculme Clinic in Birmingham. There are far too few courses of this kind. Members of the College report favourably on one in child and family psychiatry held for five days annually at the Ipswich and East Suffolk Hospital, and on those held at the Tavistock Clinic which are mentioned later. Another useful type of course for all family doctors is one in which consultant psychiatrists, general practitioners, and representatives of the social services discuss their problems together. Tape-recordings and films on this subject may in future help many doctors who work far from a teaching centre.

Psychological Medicine in the Work of a General Practitioner with a Special Interest in this Subject

Only a small percentage of the psychological casualties seen in general practice are referred to psychiatric specialists; and yet the psychiatric services in this country are working to capacity, and nearly half the hospital beds are already taken up with patients needing custodial or other psychiatric care. This service can never handle all patients requiring psychological attention, and, indeed, this would be undesirable. In future, if the people in this country are to receive better psychological treatment there must either be a vast increase in the psychiatric services or family doctors must be encouraged and trained to treat, adequately, more of these patients.

Many general practitioners develop some special interest or skill which keeps them fresh and enthusiastic, and increases their value both to their patients and to their colleagues. Such special skills may be in the general-practice aspects of obstetrics, paediatrics, geriatrics, anaesthetics, minor surgery, dermatology, and so on. A family doctor with a special interest, training and experience in psychological medicine can often diagnose and treat the commoner of these disorders more quickly than can his colleagues. His technique is, first, an extension of the simple psychotherapy that all practising doctors make use of every day, which has already been discussed; later, he may have to investigate more thoroughly unresolved conflicts or difficulties. In the opinion of the working party the special techniques of psychoanalysis and other forms of analytical treatment, hypnotism, and convulsive therapy of all kinds are, at present, outside the normal province of general practice.

A general practitioner with an interest in psychological medicine can, by himself, treat many of the more severe forms of anxiety, depression, and hysterical states by making special arrangements for this work. Hopkins (1956) is of the opinion that six sessions of half to three-quarters of an hour, at weekly intervals, are enough for many such cases in his practice. In some group practices a doctor's colleagues are often only too glad of special advice on their problem cases, without surrendering responsibility for them.

A partner who has taken a special interest in any subject leavens the whole group, for the others learn constantly from him, which is good both for the partnership and for the patients. He is in a good position to introduce to a specialist's care those who need it, to smooth the path for those who have to be admitted into hospital, and to integrate in many other ways general practice with the psychiatric services. He can reduce pressure on hospital beds by keeping some of these patients at home; he can look after others when they leave hospital, and help them to get accustomed again to the outside world. He can treat many of the chronic mentally sick in their homes—those with epilepsy, senile dementia, arrested schizophrenia, and so on; both they and their relatives may need much moral support. He may practise preventive psychiatry throughout different phases of his patients' lives—as in pre-marriage counselling, marriage guidance, parent and child guidance, in giving advice on the problems of adolescence, and in the anticipation and management of psychological problems in maturity and old age. He may be able to help the psychiatric services more directly by filling, as part of his postgraduate training, clinical assistantships or other appointments in the out-patient departments of hospitals. He may also participate in research into psychological problems which affect general practice; a field which is largely unexplored and in which organized investigation is urgently needed.

As the skill and experience of these general practitioners with a special interest in psychological medicine increases, so will their awareness of their limitations; and it is most important that these be recognized. Such family doctors will understand the considerable help which many of their patients can receive from modern treatment given by an expert; and they will realize the risks they run in trying to treat certain groups of patients themselves. They will want to refer an increasing proportion of difficult cases to their psychiatric, neurological, general medical, or other consultant colleagues. Particular care must always be taken to exclude organic disease; and the significance of symptoms which usually suggest it must be appreciated even before physical signs develop. There is always the danger that a plausible cause for illness may be found in terms of emotional conflict, and treatment on these lines may be started, when serious organic trouble is brewing; valuable time is then lost in arriving at a full diagnosis. Nervous people are not immortal.

A family doctor with special skills in the recognition and treatment of psychological illness must always remain essentially a good all-round general practitioner. He should apply them only in the field of general practice; they should be kept under control and not become a source of irritation to patients or colleagues. Unnecessary psychological investigations, like irrelevant organic tests, invariably make for bad medicine.

What Training Would a General Practitioner with a Special Interest in Psychological Medicine Require?

Before going into general practice a doctor who is specially interested in psychological medicine should spend at least six months in a psychiatric centre or out-patient clinic, or in a hospital for nervous diseases, where he would learn early diagnosis of these conditions and the principles of modern psychological treatment, taking therapeutic responsibility himself for selected cases.

After he has entered general practice he should maintain and develop his special skill by keeping in touch, if possible, with other family doctors who are interested in this subject, and by being present at as many domiciliary consultations with psychiatrists as he can. He should attend some of the lectures, demonstrations, ward rounds, and refresher courses which have already been mentioned, and work (as a contribution towards his postgraduate training) in a local psychiatric out-patient clinic, or as clinical assistant or registrar in the psychiatric department of a hospital. He could also take part in an extended course, such as the seminars which are now being attended enthusiastically at the Tavistock Clinic (Balint, 1957), and also in Leeds and Ipswich; they are held on one half-day each week and continue for at least a year. The particular advantage of such courses is that family doctors discuss their own problem patients. There is already a demand in many parts of the country for more courses of this type.

How is a General Practitioner with a Special Interest in Psychological Medicine to be Enabled to do this work?

In private practice there is usually no difficulty. Such a general practitioner charges for his extra time and skill in proportion as they are called upon; if extra time has to be spent on a patient neither he nor the doctor need feel embarrassment. In the National Health Service, however, the matter is not so simple, because here, apart from the doctor and patient, a third party is concerned—the State. Many family doctors with a special interest and training in psychological medicine feel frustrated because of lack of time and adequate reward for doing this work properly. At present a general practitioner is paid nothing extra for undertaking time-consuming treatment of this kind. He can give himself the necessary time only by limiting the number of patients on his list, thereby restricting his income, or by taking it out of his leisure hours. This unsatisfactory state of affairs must react to the disadvantage of his patients.

Summary

In this review of psychological medicine in general practice we have been impressed by the importance and size of the problem. We have suggested that this subject should be taught more thoroughly to all medical students, and that more opportunities for postgraduate training in it should be open to all general practitioners.

We have discussed how much of the family doctor's work is taken up by psychological disorders, many of them on the fringe of normality, and how well he is placed for their prevention, diagnosis, and management. We have pointed out how much good in this field every general practitioner can do himself, and on other occasions how much he and his patients benefit when he co-operates, in a team, with his many potential helpers from the social services. We have shown how advantageous it may be for a group of doctors to have one partner who, though still primarily in general practice, has been specially trained and experienced in this branch of medicine, and how much he can teach his colleagues. With increasing understanding by all general practitioners, and by the public, of the significance of anxiety and stress in health and disease, and with advances in knowledge and skill of succeeding generations of family doctors, the average standard of work in this field should be very much higher in twenty years' time than it is to-day.

Recommendations

We recommend that:

1. In the undergraduate medical curriculum greater emphasis should be laid on normal psychology and on psychological medicine.

2. In qualifying examinations there should more often be a compulsory written question (or its equivalent in the clinical or oral) on the psychological aspect of medicine, and one of the examiners should be interested in this subject.

3. More postgraduate training of general practitioners in psychological medicine should be arranged in all areas.

4. In helping their patients with psychological illnesses more opportunities should be taken by family doctors to develop team-work with the ancillary services, to all of which they should have free access; and the Ministry of Health should give more encouragement, and assistance, towards linking general practice with the social services.

5. The Ministry of Health and other appropriate bodies should investigate the possibility of giving more opportunities, and recognition, to general practitioners with a special interest in psychological medicine who have had training and experience in it.

6. In the future development of the National Health Service the fundamental role of the general practitioner, in psychological medicine as in other branches of medicine, should be recognized.

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THE PHYSICIAN AND HEALTH EDUCATION

BY

GUY W. STEUART, M.A., M.Ed., M.P.H.

Senior Lecturer, Department of Social, Preventive, and Family Medicine, University of Natal; Organizer, Health Education, Institute of Family and Community Health, Durban

The clinical situation, with its intimate doctor–patient relationship, is a peculiarly appropriate one for health education. Yet it is probably true to say that the physician has not adequately exploited his unusual educational opportunities. There are still far too many people who make relatively frequent use of their doctors but who remain with little knowledge and insight into their own states of health or those of their children. The numbers are legion indeed of those who have done little more than acquire a few esoteric terms to spice their conversations and impress their friends.

The Patient's Viewpoint and Physician's Role

To consult his doctor is, on the part of the patient, usually a decision of surrender. Even with mild complaints he feels that he can no longer carry on alone. Under a threat to his security, his immediate need is not to think for himself but rather to confide in someone who will take over a responsibility he can no longer bear.

The greater his anxiety, the more receptive is he likely to be to an authority and decisiveness that offers to restore something of certainty and orderliness to his life. Thus, although in one sense he is highly susceptible to suggestion, he is also, paradoxically enough, rather ineducable because the fundamental understanding and insight that marks sound education is not what he primarily wants.

He is seeking essentially a short-cut solution to his problem. His dominating motive is to hand over his troubles to an expert in whom he has some measure of faith. But of this expert's hidden store of skills he has little comprehension, and within limits he is emotionally set for an uncritical acceptance of what he is told.

To this extent he is in psychological continuity with all the patients of medical history who have endowed their healers with magical powers.

The physician thus finds himself in a mould, pre-cast by his patients and by society, and he would be more than human if he did not find the proffered role somewhat tempting. Not only does he himself find it satisfying in the shortest possible time to establish an unequivocal diagnosis and a clear regimen, but it is certainly demanded by his patients.

The physician's conclusions may be medically quite valid, but while he retains too much of the aura of authority he limits more than he need the patient's understanding both of his diagnosis and of his therapy. The patient comes away with that mysterious justification for his future behaviour, both rational and irrational, significantly called "doctor's orders." Thus, once he has had his complaint labelled and has been told to take a tablet at certain times, to change his diet, or to rest more often, this may mean little more to him than the anxiety-relieving rituals of magic to a primitive.